

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012	
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS			F 000			
F 156 SS=C	<p>An unannounced annual and complaint survey was conducted at this facility from August 16, 2012 through August 24, 2012. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 115. The stage two survey sample was thirty-seven (37).</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)</p>			F 156	<ol style="list-style-type: none"> 1. Corrective action: New poster was created and added to existing informational postings on all units. 2. Identify residents: All residents have the potential to be affected by the posting of this information. 		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

William Peterson

ADMINISTRATOR

9/19/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 156	<p>Continued From page 1 (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance</p>	F 156	<p>3. Measures/Systematic changes: In addition to our existing postings (e.g. You are not alone, You have rights, Report nursing home abuse immediately) the facility as created and posted information as required by Federal Tag register# 483.10, Section B, Subsection 7 (iv). The posting reads:</p> <p>Per Federal Regulation register # 483.10, Section B, Subsection 7 (iv) A statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. (Attachment 1)</p> <p>You may contact: DHSS - Division of Long Term Care & Residents Protection Milford Office 24 NW Front Street, Suite 200 Milford, DE 199631 (800) 453-0012 (302) 424-8600</p> <p>4. Monitored: Postings will be checked on Facility Rounds by management to ensure they are readable and in good condition. The postings will be replaced as necessary. Results of checks will be reported at the quarterly QA meetings by QA Administrator.</p>		9/14/12 S

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 156	<p>Continued From page 2 directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interview, it was determined that the facility failed to post a statement indicating that the residents right to file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property. Findings include:</p>	F 156			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 156	Continued From page 3 Observations during the survey period of 8/16 to 8/24/2012 conducted throughout the building on 4 out of 4 units revealed that the facility had no statement posted indicating that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility. An interview on 8/22/10 with E3 (Director of Nursing) indicated the posting could not be located.	F 156			
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of facility investigative documentation, and State Agency's (Division of Long Term Care Residents Protection/DLTCRP) investigative documentation, it was determined that the facility failed to implement policy and procedures for one (R37) out of 37 sampled residents. The facility failed to ensure that its "Abuse Protection Program" was implemented to protect other facility residents from potential abuse or mistreatment by the accused employee (E15). Findings include:	F 226			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	<p>Continued From page 4 Cross refer F323.</p> <p>Review of the facility's policy titled "Abuse Protection Program" indicated: "G. INVESTIGATE: 1. The facility will have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress. 3. Key to investigating abuse allegation is an environment that facilitates the reporting of allegations. Once reported, the facility will conduct a timely, thorough and objective investigation of all allegations. 4. Sources of investigation should include, but not limited to staff interviews, interviews of individual residents and their legal designees, clinical record review, and observation of service delivery." H. PROTECT: 1. Abuse can occur among various people within the facility and protective actions depends upon the people involved. 2. It is imperative that residents are protected from harm during an investigation."</p> <p>The facility submitted an incident report to the DLTCRP on 3/21/12 that R37 was found in bed with blood on his left 4th and 5th toes with some mild swelling and bruising as well as skin open at the base of both toes. The 5 day follow-up from the facility to DLTCRP dated 3/27/12 documented that R37 had sustained fractures of third, fourth, and fifth toes of the left foot.</p> <p>Review of DLTCRP's investigative documentation dated 3/29/12 revealed that the facility's investigative nurse, E18 interviewed R37 who</p>	F 226	<p>1. We cannot go back and change anything that has already occurred. Staff members 15, 16 and 17 had initial education on the use of the sit-to-stand and all were aware of their responsibility to report when a resident had been lowered to the floor. All of them had been employed for a year or more and had used the sit-to-stand everyday and reported multiple times resident incidents as required. All acknowledged through conversations with the DON their understanding of proper procedures for both the use of the sit-to-stand and reporting to nursing when a resident is lowered to the floor. E15 and E16 are no longer employed by the facility. E17 received a five day suspension after a recommendation for a 15 day suspension was overturned by the grievance procedure. E15 has shown supervisor the correct procedure of using the sit-to-stand. A formal in-service will be conducted and signed off on by the staff educator as well as a review of reporting responsibility, and policy on having two staff members present during transfers. Staff member will return from vacation on 9/25/12.</p>	9/25/12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	<p>Continued From page 5</p> <p>verbalized that R37 was "... alert and somewhat oriented and claimed that he was thrown into bed by a black male doctor."</p> <p>An interview with the E18 on 8/28/12 revealed that the above interview with R37 had taken place on 3/21/12.</p> <p>Review of the facility's investigative documentation included three written statements dated 3/27/12 from the three certified nursing assistants (E15, E16, and E17) who were involved in an incident when improper sit to stand transfer of R37 on 3/20/12 at approximately 4 PM was completed. E15's (assigned aide to R37) statement documented "While raising R37 his feet started going back and we lowered him down to the floor on his knees. We lifted R37 off the floor and placed him back on the bed." E16's (second aide involved with transfer) statement documented that "While putting (R37's name) onto sit to stand, he started moving his feet. Then began getting lowered to floor to reposition him into sit to stand (sic)." The third CNA's (E17) statement documented "I helped lift him up and also helped transfer him to the seat with the sit to stand."</p> <p>Review of interview notes conducted on 3/27/12 by E3 (Director of Nursing) and E18 (Investigative Nurse) revealed that E15 and E16 verbalized that R37 had sock on rather than shoes and the lower legs straps were not secured which led to R37 being on the floor on his knees. Additionally, the facility failed to notify the licensed nurse when R37 had to be lowered to the floor for an assessment.</p>	F 226	<p>2. All residents with allegations of abuse are at risk if the staff is allowed to continue care while completing the investigation. The facility policy on protecting residents has been revised to include removing staff from resident care if under investigation (Attachment 2).</p> <p>3. All staff will be in-serviced on the revised policy by the staff educator. All staff will be in-serviced on the importance of notifying nursing to complete an assessment, if resident is lowered to the floor. All staff will be in-serviced on having two staff present during a transfer.</p> <p>4. The nurse investigator will ensure all allegations of abuse will be investigated per policy and will notify DON/ADON to remove staff from resident care pending results of the investigation. The nurse investigator reports at quarterly QI all incident reports including allegations of abuse.</p>	<p>9/11/12</p> <p>9/30/12</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	<p>Continued From page 6</p> <p>During the facility's investigation of the above incident, the facility's video footage was reviewed and written summary completed by E9 (Administrative Nurse) on 3/29/12 which documented on 3/20/12 at 10:57 PM, R37 was brought from the nursing station into his room by E15 and E15 exited the room few minutes later with the sit to stand device which was pushed into an alcove area in the hallway. Thus, R37 was transferred to bed without two staff members.</p> <p>Interview with E27 (Trainer Educator) on 8/24/12 at approximately 12 noon revealed that no in-service was provided to E15, E16, or E17 following the above incident. An interview with E3 (Director of Nursing) on 8/24/12 at approximately 10 AM confirmed that in-service was not provided to E15, E16, or E17 since it was her assessment that each of the staff members were aware that shoes were required to be used for the sit to stand device.</p> <p>Review of the facility's "Daily Staffing" Sheet for 3/21/12, 3/22/12, 3/23/12, 3/24/12, 3/25/12, 3/26/12, and 3/27/12 revealed that E15, E16, and E17 continued to care for E37 and other residents in the Gold Unit.</p> <p>A subsequent interview with E3 on 8/24/12 at 12:30 PM confirmed that during the incident investigation, the above staff continued to care for R37 as well as other residents in the Gold Unit who required the sit to stand device for transfer.</p> <p>Although R37 had sustained fractures of his left three toes and R37 verbalized an allegation of abuse during the above interview, the facility failed to protect R37 and other residents during</p>	F 226			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	Continued From page 7 the investigation.	F 226			
F 241 SS=D	<p>During an interview with E1 and E3 on 8/24/12 at approximately 1 PM confirmed that E15, E16, and E17 continued to be assigned to the residents in the Gold Unit including R37 during the facility's investigation.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations it was determined that the facility failed to promote care for residents in a manner and in an environment that maintained or enhanced each resident's dignity for 2 (R14 and R49) out of 37 sampled residents. Findings include:</p> <p>1. The following observation was made on 8/16/12 during breakfast in the main dining hall:</p> <p>At 8:32 AM, E24 (CNA) used the clothing protector that R49 was wearing to wipe his mouth and chin instead of the paper napkins that were in use in the dining hall. The clothing protector was not replaced.</p> <p>2. The following observation was made on 8/16/12 during breakfast in the main dining hall:</p> <p>At 8:36 AM, R14 was assisted with her meal by</p>	F 241	<p>1. We cannot go back and change what the surveyor observed during the survey. The CNA staff members were not identified. The facility did have CNA students from Polytech Adult Education that day that were helping the residents eat their morning meal (Attachment 3-A).</p> <p>Clothing protectors are used to protect the residents' clothes from spillage and food droppings although some residents do choose to use them as napkins, as they are removed when the resident is finished with the meal. Paper napkins are not routinely used as cloth napkins are available. R14 has always worn a clothing protector and because our staff members know the residents well, the staff member may have already known it was routine for R14 to wear one. R14's comprehensive assessment indicates from family that resident is unable to choose and does not give understandable answers and rarely makes decisions (Attachments 3-B). Once again, the clothing protector is used to protect the resident's clothes from spillage and food droppings which was accomplished for R14.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 241	Continued From page 8 E28 (CNA). E28 applied the clothing protector without any indication to R14 that she was doing so.	F 241	2. All residents that wear clothing protectors during meal time are at risk for having them applied without asking or having them used to wipe a resident's face to remove excess food. Staff members only apply clothing protectors to residents that are unable to apply themselves. Dining will ensure napkins are available for every resident at meal time.	9/30/12	
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observation and interview, it was determined that the facility failed to ensure that one (R38) resident out of 37 sampled residents received an ongoing program of activities designed to meet the physical, mental and psychosocial well-being of the resident. Findings include: R38 was admitted to the facility with diagnoses including PEG tube, malabsorption, atrial fibrillation, prostate cancer, and diarrhea. R38 had a care plan for Activity initiated 11/3/11 and last updated on 8/8/12. The goal of the care plan (dated 2/28/12) was "attend activities 4 times per week." The plan also noted examples of how R38 would respond to activity or 1:1 settings and a preference for music activities, watching TV and having something in his hands. Review of R38's records revealed a physician's order dated 8/13/12 that stated "patient is to remain on bedrest until further notice due to	F248	3. All staff will be in-serviced by the staff educators to ask /inform residents before applying a clothing protector. All staff will be in-serviced to use napkins to wipe excess food from the residents' faces. Polytech Adult Education students will be sent a letter to educate their students on the same (Attachment 3-C & 3-D). 4. All meals will be supervised by nursing supervisors to ensure clothing protectors are only applied after asking residents and to ensure napkins are used to remove excess food. 1. The care plan for R38 was updated with Surveyor present. The care plan reflects resident preferences with music and TV being alternated on his TV in his room by all staff. Activity staff offer 1:1's 5 days a week. R38's spouse visits several times a week and spends the day with him (Attachment 6A). 2. Any resident who has a change in MD orders which impacts a resident's ability to attend activity programs &/or limits social opportunities has the potential risk for not having care plans updated.	9/11/12 9/30/12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 248	Continued From page 9 wound and skin issues". Review of R38's activity log from 6/1/12- 8/1/12 revealed that R38 had participated in a combination of 1:1 and activities such as music, entertainment, video and sitting outside room or visiting with family approximately 4 times weekly. R38's activity quarterly review dated 8/8/12 noted "to attend musical entertainment when medically able" and also "sit in his wheel chair at the nurses station or lounge." R38's activity log from 8/1/12 -8/21/12 documented 3 activities prior to 8/13/12. There was no evidence of 1:1 activities provided during that time. Observation of R38 on 8/17/12, 8/20/12-8/22/12 noted the resident in bed with the TV on except when taken by stretcher to an appointment the afternoon of 8/21/12. The CNA on day shift on 8/21/12 placed a stuffed animal in R38's hand after completion of incontinence care. An interview with E23 (Activities Director) on 8/22/12 at 11:45 AM revealed that she was unaware of the 8/13/12 order for bedrest. Findings were reviewed with E23 who confirmed 1:1 visits by an activities aide should have occurred twice weekly prior to 8/13/12 and there was no evidence that the facility provided in room activity for a resident who was on bedrest. E23 stated she would change the 1:1 activity to 4 times weekly.	F 248	3. Nursing leadership currently reviews all new MD orders each morning prior to daily report, therefore this will be added as an agenda item to this meeting. This will ensure that any potential identified resident will quickly be identified in need of a care plan revision, which addresses the changing needs of the resident. The Activity Director will attend morning report each work day to keep informed of residents' medical changes. If the Activity's Director is not present for the morning report meeting, nursing will email the update. All activity staff will be in-serviced on the importance of documentation of all residents pertaining to their program attendance and in particularly those residents on bed rest or room isolation by Activity Director. 4. Audits will be completed by Activity Director on a monthly basis for residents who experience a change in status which impacts the resident's ability to participate in activities &/or socialization. The audit will monitor staff compliance that care plans were revised in a timely manner and activity staff charting is thorough & complete (Attachment 6B). The Activity Director will report results at quarterly QI.	9/19/12 9/24/12	10/12 10/24/12
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.				

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 272	Continued From page 11 (R32) out of 37 sampled residents in the area of terminal prognosis. Findings include: R32 was admitted to the facility on 10/21/09 and was under Hospice (end of life) services since admission. A sticker on the front of chart read "Delaware Hospice". The POLST (physician ordered life sustaining treatment) form listed Alzheimer's Dementia under terminal condition and listed resident as DNR (Do Not Resuscitate). Physician orders for renewal of Hospice services were dated 12/29/12 and 6/7/12. Review of the minimum data set assessments (MDS) including the annual dated 12/21/12 and quarterlies dated 6/15/12 and 3/30/12 documented in section J1400 "No" for the question "Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months". An interview on 8/22/12 at 9:40 AM with E20 RNAC (Registered Nurse Assessment Coordinator) and E11, RNAC revealed that the facility had miscoded the MDS and it should have coded the resident with a terminal diagnosis.	F 272			
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 279			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012	
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 279	<p>Continued From page 12 assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to develop a comprehensive care plan for an identified need for four (R21, R43, R23, and R72) out of 37 sampled resident. Findings include:</p> <p>1. Cross refer F329 example #1. R21 had current physician orders for Trazodone 100 mg each evening for insomnia dated 8/21/12 but originally initiated on 12/20/11.</p> <p>R21's had a care plan for psychotropic medications potential for adverse side effects related to use of anxiety medication, antipsychotic medication. Interventions included: medicate as ordered: Seroquel, Trazodone, and lorazepam. Evaluate effectiveness and adverse effects of medication.</p> <p>Review of the care plan lacked evidence that insomnia was being addressed.</p> <p>An interview on 8/22/12 at 9:40 AM with E11</p>			F 279	<p>1. Care plan for R21 was revised by the RNAC to include insomnia (Attachment 5A). R43 had his care plan updated by RNAC to include insomnia (Attachment 5B). R72 had his care plan updated by the RNAC to address insomnia desired outcomes and the side effects that needed to be monitored (Attachment 5C). R23 had his care plans updated by the RNAC to include insomnia. (Attachment 5D).</p> <p>2. Residents that have orders for medications to address insomnia are at risk for not having a comprehensive care plan. A chart audit will be completed by the RNACs to identify residents that receive medications for insomnia to ensure care plans are in place.</p> <p>3. Daily orders will be reviewed by the Nursing Supervisors as well as the facility RNACs through the electronic medical record. When orders are obtained for medication to address insomnia, the RNACs will ensure a care plan is in place.</p> <p>4. A monthly report of all anti-psychotics, anti-depressants, hypnotics and sedatives is received by DON from pharmacy. The ADON will review the report and will audit five residents per month to ensure care plan is in place if required for insomnia. The ADON will report findings at quarterly QI for 100% x two quarters.</p>		<p>9/11/12</p> <p>9/11/12</p> <p>9/11/12</p> <p>9/11/12</p> <p>9/30/12</p>

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 279	<p>Continued From page 13</p> <p>(Registered Nurse Assessment Coordinator) confirmed that insomnia was not addressed in the care plan.</p> <p>2. Cross refer F329 example #2. R43 had diagnoses which included depressive disorder, anxiety associated with depression, and insomnia.</p> <p>The resident had current physician's orders that included an order dated 8/10/12 for zolpidem (hypnotic) 5 mg daily for insomnia. Prior to this order R43 had been receiving the zolpidem as needed each evening with a physician's order date of 12/21/11.</p> <p>Review of the care plan lacked evidence that insomnia was being addressed.</p> <p>An interview on 8/22/12 at 9:40 AM with E11 the RNAC confirmed that there was no care plan for insomnia.</p> <p>3. R72 had a diagnosis of insomnia initiated on 12/08/11, for which, he was being given Trazodone HCl, 50 mg, at bedtime, daily.</p> <p>R72 had a care plan for psychotropic medications potential for adverse side effects related to use of antipsychotic medication. Interventions included: medicate as ordered: Seroquel. Evaluate effectiveness and adverse effects of medication.</p> <p>However there was no care plan developed to address insomnia for this resident nor the desired outcomes of this medication regime. The potential side effects were not being monitored.</p>	F 279			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 279	Continued From page 14 An interview on 8/24/12 with E11 confirmed that insomnia was not addressed in the care plan. 4. R23 was admitted 10/8/10 to the facility with diagnoses including insomnia. R23 had current (August 2012) physician orders for Trazodone 50mg at bedtime daily for insomnia. The trazodone dosage was clinically contraindicated for reduction per physicians exam dated 7/9/12 when complaints of increased difficulty falling asleep were reported. R23 had a care plan for psychotropic medications potential for adverse side effects related to use of anxiety medication, antipsychotic medication. Interventions included: medicate as ordered: Trazadone and Sertraline. Review of the care plan lacked evidence that insomnia was being addressed. An interview on 8/23/12 @ 3:00 PM with E11 (RNAC) confirmed that there was no care plan for insomnia.	F 279			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility	F 280	1. The care plan for R38 was updated with Surveyor present. The care plan reflects resident preferences with music and TV being alternated on his TV in his room by all staff. Activity staff offer 1:1's 5 days a week. R38's spouse visits several times a week and spends the day with him (Attachment 6A).		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 280	<p>Continued From page 15</p> <p>for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that for one (R38) out of 37 sampled residents the facility failed to revise the care plan to reflect the needs of the resident. Findings include:</p> <p>Cross refer F248 example #1.</p> <p>Review of R38's records revealed a physician's order dated 8/13/12 that stated "patient is to remain on bedrest until further notice due to wound and skin issues".</p> <p>R38 had a care plan for Activity (initiated 11/3/11) updated on 8/8/12. The goal of the care plan (dated 2/28/12) was "attend activities 4 times per week." It also noted examples of how R38 would respond in activity and 1:1 settings.</p> <p>R38's activity quarterly review dated 8/8/12 noted "to attend musical entertainment when medically able" and also "sit in his wheel chair at the nurses station or lounge."</p> <p>An interview with E23 (Activities Director) on</p>	F 280	<p>2. Any resident who has a change in MD orders which impacts a resident's ability to attend activity programs &/or limits social opportunities has the potential risk for not having care plans updated.</p> <p>3. Nursing leadership currently reviews all new MD orders each morning prior to daily report, therefore this will be added as an agenda item to this meeting. This will ensure that any potential identified resident will quickly be identified in need of a care plan revision, which addresses the changing needs of the resident. The Activity Director will attend morning report each work day to keep informed of residents' medical changes. If the Activity's Director is not present for the morning report meeting, nursing will email the update. All activity staff will be in-serviced on the importance of documentation of all residents pertaining to their program attendance and in particularly those residents on bed rest or room isolation by Activity Director.</p> <p>4. Audits will be completed by Activity Director on a monthly basis for residents who experience a change in status which impacts the resident's ability to participate in activities &/or socialization. The audit will monitor staff compliance that care plans were revised in a timely manner and activity staff charting is thorough & complete (Attachment 6B). The Activity Director will report results at quarterly QI.</p>	9/19/12	9/24/12

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

If continuation sheet Page 17 of 53

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 17</p> <p>1. R40's quarterly Minimum Data Set (MDS) assessment dated 5/25/12 indicated he was moderately impaired for decision making.</p> <p>R40's physician order sheet for July 2012 included an allergy to shrimp. The July 2012 Medication Administration Record (MAR) also included under allergy shrimp intolerance. The clinical record located on the nursing unit contained an allergy sticker that had IV (intravenous) dye and shrimp intolerance documented.</p> <p>Review of facility documentation revealed that on 7/3/12, R40 was served and consumed shrimp creole during dinner. The resident developed watery eyes and redness to both cheeks. The physician designee was called and the resident received a dose of Benadryl (antihistamine). Review of the investigation further revealed that although the shrimp allergy was documented on the dinner meal ticket, the staff who plated the meal and the staff who served the resident failed to notice the shrimp allergy. A staff person who entered the dining room during the meal noticed R40 was eating shrimp and notified a supervisor. The resident had no further effects from the shrimp consumption.</p> <p>An interview on 8/23/12 at 9:30 AM with E21 (Food Service Director) revealed that the shrimp creole was a new item on the meal tracker system and had not been added into the allergy group. E21 stated that had the new entree been added to the allergy group the facility staff person who did the meal selection data entry would not have been able to enter the shrimp dish for this resident into the computer system. E21 further</p>	F 309	<p>3. A color printer was placed in the dietary department. Meal ticket settings were adjusted by the food service director to force food allergies to automatically print in red ink on the ticket and be easily identified during meal service. The tray expediter in the dining room will be the official "checker" of all trays before delivering to the table and will help to ensure that there are no prohibited foods on resident trays. An in-service was held with food service staff regarding the color printer and that allergies would be placed on bold, red ink at the top of the resident's meal ticket and for them to be aware (Attachment 7A). An in-service will be done with nursing staff by staff educators to review meal tickets while serving in dining room to check for allergies and to ensure residents are not receiving an item that resident has an allergy to.</p> <p>4. The registered dietician will conduct weekly audits on resident allergies in the dining room to ensure residents are not receiving food items that they are allergic to. The audits will be reported on at the quarterly QI meetings by the dietician. The frequency of the audit will decrease to monthly after the first three months of 100% compliance. The audit will cease after four consecutive quarters of 100% compliance.</p>	7/9/12 7/9/12 7/10/12 9/30/12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 18</p> <p>revealed that the computer system had now been updated for these new menu items. E21 also stated that after this incident the meal tickets were printed on a color ink printer with the allergies in red to alert staff.</p> <p>Due to multiple failures in the dietary system, R40 received and consumed a meal that contained shrimp despite a plan of care that indicated a shrimp allergy.</p> <p>Cross refer F323.</p> <p>2. Review of R37's nurse's notes dated 3/21/12 and timed 6:29 AM documented "Resident noted this AM with blood on his socks, linen, and left foot. Foot cleansed with nss (normal saline solution) with the following findings: 4th and 5th left toes are bruised/dark colored, cuts/splits on bottom side of toes with bleeding noted, small tear/cut on top of 5th toe; both toes are swollen; 4th toe is crooked; toes are painful, Tylenol administered. (Name of nurse practitioner, E12) notified, resident to remain resting NWB (no weight bearing) until seen by her this morning."</p> <p>R37's March 2012 MAR documented that R37 was administered acetaminophen 650 mg. (milligram) on 3/21/12 at 6:15 AM, 8 AM, and 1:45 PM for pain, however, record review lacked evidence of a pain assessment prior to and post administration of the above medication.</p> <p>Subsequently on 3/21/12 at approximately 1:42 PM, x-ray report identified an "old fracture of the left fifth toe", however, the final report dated 3/21/12 and timed 3:47 PM included an addendum "exact fracture age is difficult to assess based on plain films that were submitted.</p>	F 309	<ol style="list-style-type: none"> 1. We cannot go back and add documentation to R37's medical chart for a pre- and post-pain level. R37 has not voiced any complaints of pain or been medicated without documenting properly as of 9/1/12 (Attachments 7B-H). 2. Any residents that has pain has a potential risk to not have proper documentation in place that identifies assessment made prior to medication being given and after medication was given to indicate effectiveness. A chart audit will be completed by nursing leadership to ensure documentation is in place per facility pain policy. 3. All nursing staff will be in-serviced by the staff educators on the facility pain policy. The facility will be moving forward to the EMAR which will enhance completion of all required documentation. 4. The building supervisor will randomly review five charts per unit per month to ensure documentation is completed properly. The building supervisor will report findings at quarterly QI. Once the EMAR is in place, exception reports will be reviewed daily by unit supervisors to ensure all documentation is completed. 	9/30/12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 19</p> <p>Fracture could be compatible with a recent injury."</p> <p>An interview with E24 (nurse) who administered the acetaminophen at 8 AM and 1:45 PM on 8/27/12 at approximately 2 PM revealed that R37 offered complaints of pain in his left foot upon movement only. E24 further verbalized that she normally assessed the pain level prior to and post administration of a pain medication, however, did not recall whether she assessed the pain or not.</p> <p>Findings were reviewed and confirmed with E3 (Director of Nursing) on 8/27/12 at approximately 12:30 PM.</p> <p>3. Review of R83's most recent quarterly MDS assessment dated 5/18/12 revealed that R83 was severely impaired for daily decision making, required extensive assistance of two staff person for toileting and was frequently incontinent of bowel and bladder functions.</p> <p>Review of R83's June 2012 physician's orders revealed the following as needed orders for treatment of constipation:</p> <ul style="list-style-type: none"> - Milk of Magnesia (MOM, a laxative) 30 cc (cubic centimeters) by mouth daily PRN (as needed) on day shift for small or no bowel movement (BM) in 3 days. If no relief in 8 hours after MOM, proceed with bisacodyl suppository on 3-11 shift. - bisacodyl (laxative) 10 mg. (milligrams) suppository rectally daily PRN on 3-11 shift if no relief 8 hours after MOM. If no relief 8 hours after bisacodyl suppository, proceed with enema on 11-7. 	F 309	<ol style="list-style-type: none"> 1. We can not go back and make changes to documentation for R83. Current documentation reveals that R83 has not gone greater than three days without a bowel movement (Attachment 7I). 2. All residents have a potential to be at risk for constipation if not monitored and physician orders are not followed. Our electronic medical record has the ability to generate a report for any residents that has had no bowel movements in the last three days. The ADON reviewed the report and ensured bowel protocol was initiated by staff nurses on the units. Alert messages are sent to the nurses' alert charting for no bowel movement for three days or if only a small bowel movement occurred in a three day period (Attachments 7J, 7K). 	9/13/12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 20</p> <p>Review of the "Certified Nursing Assistant AM, PM, and Night Stool Output" Report for June 2012 revealed that R83 had a medium, hard BM during the 3PM-11 PM shift on 6/9/12. There was small, soft BM documented during the day shift on 6/13/12 followed by three additional shifts with no BM activity documented. During the 3 PM- 11 PM shift on 6/14/12, R37 was documented as having a medium, soft BM.</p> <p>There was no evidence that the facility assessed R83 for constipation and/or followed the resident's physician's order. Additionally, review of the June 2012 MAR lacked evidence that any of the PRN orders for constipation was implemented.</p> <p>Additional review of the "Certified Nursing Assistant AM, PM, and Night Stool Output" report for June 2012 revealed that R83 had no documented BM activity beginning on the 3 PM-11 PM shift on 6/16/12 through 3 PM-11 PM shift on 6/20/12 or 14 shifts without BM activity. Again, there was no evidence that the facility assessed R83 for constipation and/or followed the resident's physician's order. Additionally, review of the June 2012 MAR lacked evidence that any of the PRN orders for constipation were implemented.</p> <p>An interview with the E31 (Nurse Unit Manager) on 8/27/12 at approximately 1 PM revealed that the night shift supervisor prints a report when a resident has a small BM or no BM for three days and reports to the day shift nurse that pharmacological interventions need to be implemented. E31 further verbalized that there are "more than one place" in the facility's</p>	F 309	<p>3. The facility bowel protocol/bowel movement monitoring policy was revised (Attachment 7L). Nursing staff will be in-serviced on revised bowel protocol by staff educators. The night nursing supervisor pulls the bowel report every night and distributes it to each unit to address any residents that triggers as having no bowel movement or a small bowel movement in the last three days. The bowel protocol is initiated by the unit nurse and the nurse is signing off on the report sheet that the bowel protocol has been initiated.</p> <p>4. Each unit supervisor reviews the bowel movement report on the following day to ensure resident has had bowel movement.</p>	9/11/12	9/30/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 21 electronic medication records system to document BM activity. Lastly, E31 confirmed the above findings.	F 309			
F 314 SS=E	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that the facility failed to provide the care and services necessary to promote wound healing for one (R46) out of 37 sampled residents. Findings include: R46 was admitted to the facility in 2008 with diagnoses including dementia, diabetes, chronic kidney disease and chronic obstructive pulmonary disease (COPD). A quarterly MDS (minimum data set) assessment, dated 6/29/12, listed R46 with moderate cognitive impairment, rarely/never understood, non-ambulatory and he required either 2+ person extensive assistance or was totally dependent for activities of daily living. R46 was hospitalized from 7/26/12 to 7/30/12.	F 314	1. The current order for R46 is in place and has been transcribed correctly to the TAR (Attachments 8A & 8B). The wound report from 9/6/12 identifies the left and right heels have both improved (Attachments 8C). 2. All residents that are being treated for wounds are at risk for not having orders in place and correctly transcribed to the TAR. The wound care nurse will complete an audit of all wound care orders to ensure that they are in place and have been properly transcribed to the TAR (Attachment 8D). 3. The wound care nurse will be responsible for placing all orders needed as determined on weekly wound care rounds. The wound care nurse will continue to create and a weekly report of wound rounds which is reviewed by nursing leadership. 4. Each unit supervisor will pull a new order report daily from the electronic medical record. Any new wound care order will be checked to ensure it was transcribed to the TAR properly. The facility will be moving to the electronic MAR and TAR in the next 60-90 days. All orders entered will automatically populate to the MAR/TAR.	9/14/12 9/14/12 10/24/12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	<p>Continued From page 22</p> <p>Upon readmission to the facility, R46 was found to have bilateral boggy (mushy) heels with a darkened area on the right heel (suspected deep tissue injury) and redness to the left heel. Treatment was ordered with Skin Prep to both heels.</p> <p>On 8/13/12, physician orders were written to change the right heel treatment from Skin Prep to Bacitracin and to continue Skin Prep to the left heel.</p> <p>On 8/15/12, a nurse practitioner (NP) did the residents weekly wound evaluation. The right heel worsened and the NP changed the treatment from Bacitracin to Calcium Alginate. The left heel was listed as "no change" and to continue treatment with Skin Prep.</p> <p>On 8/22/12, E35 (contracted wound care nurse) and E9 (facility infection control nurse) performed the weekly wound evaluation with 2 surveyors present. E35 (WCN) stated that the right heel was "improved."</p> <p>Review of the 8/22/12 Wound Evaluation Form conversely stated that the right heel wound had "worsened". Treatment with Calcium Alginate was continued. The left heel was listed as "no change" and to continue Skin Prep.</p> <p>Review of the August 2012 treatment administration record (TAR) revealed that R46 incorrectly received Bacitracin to the right heel from 8/15 to 8/23/12. Despite treatment order changes to Calcium Alginate per the 8/15 and 8/22/12 weekly wound evaluations, the TAR lacked treatment orders with Calcium Alginate.</p>	F 314			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012	
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 314	Continued From page 23 Additionally, Skin Prep for the left heel (reordered on 8/13, 8/15 and 8/22/12) was not administered since 8/12. R46 had a previous order for Skin Prep dated 8/9/12 which was marked as discontinued on 8/13/12. There was no order for Skin Prep written onto the TAR since the 8/9/12 order. E9 (infection control nurse) was interviewed on 8/23/12. E9 confirmed that the Calcium Alginate and Skin Prep orders were not entered into the computer system and not transcribed onto the TAR. She additionally confirmed that R46 subsequently failed to receive left and right heel treatments as previously stated. E9 stated that one of the NP 's enters her own orders and she enters wound treatment orders for everyone else. E9 was advised on 8/24/12 that R46 's TAR continued to lack a treatment order for Skin Prep to the left heel. Copies of the order in the computer system and the TAR were provided post interview on 8/24/12.			F 314			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.			F 315			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 315	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R82) out of 37 sampled residents the facility failed to provide the appropriate treatment and services to restore as much normal bladder function as possible. Findings include: R82 was admitted to the facility on 4/24/12 with diagnoses which included congestive heart failure, hypertension, dementia, and cerebral vascular accident. The admission MDS assessment dated 4/30/2012 documented that R82 was moderately impaired for daily decision making, required supervision for transfer and was independent with toileting and was always continent of urine. The subsequent 90 day MDS assessment dated 7/27/2012 documented R82 was now occasionally incontinent of urine. Review of the facility's electronic documentation for bladder continence for 7/21/2012 -7/27/12 revealed R82 was incontinent of urine during two, 3 PM-11 PM shifts on 7/23/12 and 7/24/12. Review of the urinary incontinence from 7/20/12-7/27/12 revealed R82 was incontinent X3 on night shift on 7/24/12. Record review lacked of an assessment of the change in continence based on the above, the facility failed to comprehensively assess the resident.	F 315	<ol style="list-style-type: none"> R82 will have a three day voiding diary completed to assess if there is a change in his continence (Attachment 9). All residents that are continent have the potential to be at risk for not having a change assessed. Residents that are continent will be identified on each unit by the unit supervisors through review of records and communication with staff. Once identified, a cross reference will be done with the MDS and the RNACs to ensure the proper coding is in place. If the cross reference reveals a discrepancy, the RNAC will investigate and initiate a three day voiding diary to assess and evaluate the resident's bladder function. All staff will be in-serviced by staff educators on reporting changes in bowel and bladder habits of residents. When RNACs do MDS assessments, any change in continence, regardless of the time frame, will have an assessment completed. Unit supervisors will maintain a list of residents that are continent on their unit and will review weekly documentation to ensure residents remains without change. 	9/17/12	9/30/12
				9/30/12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 315	<p>Continued From page 25</p> <p>Review of the facility's policy titled "Bowel/Bladder Incontinence Management Program" indicated: "Policy: A. All residents on admission, when there is a change in incontinence, a change in overall condition, or upon the removal of an indwelling catheter will be assessed or three (3) days for incontinence of bowel and bladder and will receive the appropriate care and services to restore as much bowel and bladder continence as possible."</p> <p>Record review lacked evidence that an assessment of the change of continence was completed.</p> <p>R82 was observed during the survey on 8/21/12 at approximately 9 AM and on 8/22/12 at approximately 8:42 AM appropriately dressed in day wear with no evidence of urinary incontinence.</p> <p>An interview with E32 (Certified Nursing Assistant) on 8/23/12 at 10 AM revealed that she frequently cared for R82 and that R82 was always continent when she worked the 6 AM-2 PM shifts.</p> <p>Additional review of the bladder continence record for August 2012 revealed R82 had additional episodes of urinary incontinence on 8/5/12 and 8/6/12.</p> <p>An interview with E3 (Director of Nursing) on 8/23/12 at approximately 10 AM confirmed that the facility failed to assess the change in continence.</p>	F 315			
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 26</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review, and review of additional facility documentation, it was determined that the facility failed to ensure that one (R37) out of 37 sampled residents received adequate supervision and assistance devices to prevent accidents. The facility failed to ensure that R37's lower legs were secured (strapped) and that R37 had proper footwear (shoes) during the use of a sit to stand lift device for transfer from bed to the wheelchair. These failures resulted in R37's feet slipping and the resident falling to his knees. Later that evening a Certified Nursing Assistant (CNA) transferred R37 back to bed without another staff person. Subsequently following these improper transfers, during the next shift (11 PM-7 AM), R37's left foot was observed with bruising, swelling, and lacerations of the foot which required further evaluation and treatment in the emergency room. In the emergency room, x-ray verified R37's acute fractures of the left third, fourth, and fifth toes. Findings include:</p> <p>R37 was originally admitted to the facility on 7/1/08 with diagnoses including diabetes mellitus type II, hypertension, cerebrovascular disease, chronic obstructive pulmonary disease,</p>	F 323	<p>1. We cannot go back and make any changes to what occurred to R37. The three staff members involved in transferring the resident were long term employees of one year or more. It was determined through the facility investigation that all staff involved had been educated on the facility policy of having two staff members during transfers, reporting residents that are lowered to the floor, and the proper use of the sit-to-stand. Involved employees used the sit-to-stand everyday and had been involved in reporting multiple incidents during their employment. Two of the staff members are no longer employed with the facility. The third staff member has shown the supervisor the proper technique to use the sit-to-stand, and has had a five day suspension. A second more formal education will be given by the staff educator on the proper use of the sit-to-stand, the policy on having two staff present during transfers and the responsibility of the CNA to report when an incident of lowering a resident to the floor happens.</p>	9/30/12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 27</p> <p>hypothyroidism, delusional disorder, and hyperlipidemia.</p> <p>Review of R37's annual Minimum Data Set (MDS) assessment dated 2/3/12 documented that R37 was moderately impaired for daily decision making, required extensive assistance of two person physical assistance with bed mobility, total assistance of two for transfer, did not ambulate, had no functional limitation in range of motion, was frequently incontinent of urine, and had history of two or more falls since admission/entry or reentry or prior assessment. Lastly, R37 height and weight was 67 inches and 241 pounds respectively.</p> <p>A care plan for "potential for trauma-fall" dated 12/2/11 included intervention for "sit to stand lift for transfers."</p> <p>Review of nurse's notes dated 3/21/12 and timed 6:29 AM documented "Resident noted this AM with blood on his socks, linen, and left foot. Foot cleansed with nss (normal saline solution) with the following findings: 4th and 5th left toes are bruised/dark colored, cuts/splits on bottom side of toes with bleeding noted, small tear/cut on top of 5th toe; both toes are swollen; 4th toe is crooked; toes are painful, Tylenol administered. (Name of nurse practitioner, E12) notified, resident to remain resting NWB (no weight bearing) until seen by her this morning."</p> <p>Subsequently, R37 had an x-ray of his left foot at approximately 8:41 AM on 3/21/12 at the facility and the results were available at 1:42 PM which initially identified an old fracture of the left fifth toe, however, the final report dated 3/21/12 and</p>	F 323	<p>2. All residents that use the sit-to-stand for transfers are at a potential risk for staff not to follow proper procedures and facility policy. All staff will be in-serviced by the staff educators on the proper procedure to use the sit-to-stand, on the facility policy to have two staff present when using the sit-to-stand, as well as reporting if a resident is lowered to the floor.</p> <p>3. The proper steps to take in using the sit-to-stand will be created and placed on each unit as a reference for the staff. All new hires will be educated and signed-off on a sit-to-stand competency by the staff educators as part of their facility training. Safe transfer policy and reporting incidents will continue to be part of the new hire training (Attachments 10A & 10B).</p> <p>4. A competency form has been created (Attachment 10C). The building supervisor will check off five random staff members per month. The results will be reviewed at quarterly QI by the building supervisor. Any staff member that does not pass the competency check will be addressed on the spot with education from the supervisor.</p>	9/30/12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 28</p> <p>timed 3:47 PM included an addendum "exact fracture age is difficult to assess based on plain films that were submitted. Fracture could be compatible with a recent injury."</p> <p>At approximately 2:31 PM on 3/21/12, R37 was sent to the emergency room for further evaluation. Review of the hospital medical records dated 3/21/12 documented that the resident sustained a blunt trauma to the left foot resulting in fractures of third, fourth, and fifth toes as well as laceration of the foot. Closed reduction of the toes was completed</p> <p>The facility's investigative documentation were reviewed which included three written statements from the three certified nursing assistants (E15, E16, and E17) who were involved in a sit to stand transfer of R37 on 3/20/12 at approximately 4 PM. E15's (assigned aide to R37) statement documented "While raising R37 his feet started going back and we lowered him down to the floor on his knees. We lifted R37 off the floor and placed him back on the bed." E16's (second aide involved with transfer) statement documented that "While putting (R37's name) onto sit to stand, he started moving his feet. Then began getting lowered to floor to reposition him into sit to stand (sic)." The third CNA's (E17) statement documented "I helped lift him up and also helped transfer him to the seat with the sit to stand."</p> <p>Review of interview notes conducted on 3/27/12 by E3 (Director of Nursing) and E18 (Investigative Nurse) revealed that E15 and E16 verbalized that R37 had sock on rather than shoes and that a licensed nurse was not made aware of R37 being on the floor on his knees.</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 29</p> <p>Additional interview note conducted by E19 (Director of Human Resources) on 3/30/12 with E16 revealed that R37 did not have shoes or leg straps in place during the above transfer.</p> <p>During the facility's investigation of the above incident, the facility's video footage was reviewed and written summary completed by E9 (Administrative Nurse) on 3/29/12 which documented on 3/20/12 at 10:57 PM, R37 was brought from the nursing station into his room by E15 and E15 exited the room few minutes later with the sit to stand device which was pushed into an alcove area in the hallway. There was no one else seen with E15.</p> <p>Review of the facility's policy titled "Safe Lifting/Transferring of Residents" revealed that the facility was a "No Lift Facility" and that two staff members were required for the use of the "sit to stand" lift device. In addition, "5. Combative and Mentally Impaired Residents. a. In most situations, this type of resident can be lifted using the appropriate mechanical lifting device; however, more care providers may be required to assist."</p> <p>An interview with E27 (Trainer Educator) on 8/24/12 at approximately 12 noon revealed although the above policy failed to include that shoes must be worn and leg straps must be utilized, this was discussed during an in-service on the use of the sit to stand device. An interview with E3 on 8/24/12 at approximately 10 AM confirmed that shoes must be worn and legs must be strapped when using this device.</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	Continued From page 30 Although R37 was care planned to use the "sit to stand" lift device for transfer, the facility failed to ensure that R37 had proper foot wear to minimize the foot from slipping and failed to secure R37's lower legs during the transfer at approximately 4 PM on 3/21/12. Additionally, when R37 was transferred into the bed on 3/21/12 at 10: 57 PM, the facility failed to ensure that R37 was transferred by two staff members.	F 323			
F 329 SS=E	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	1. We cannot go back and add documentation to the medical record. A memo was sent out to the nursing staff during survey from the ADON to ensure documentation was being completed on the side effects of the anti-psychotic medications (Attachment 11A). R21, R43, R95, R114, R64 and R57 all have documentation in place to monitor side effects of medication (Attachment 11B-11F). R21 and R43 have had sleep patterns added to nurse to do list for documentation (Attachment 11G, 11H).		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 31</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview it was determined that the facility failed to adequately monitor the drug regimen for eight (R21, R43, R72, R95, R114, R102, R64, and R57) out of 37 sampled residents. Findings include:</p> <p>1. R21 had diagnoses which included dementia with behavioral disturbances.</p> <p>R21 had a current physician orders for Trazodone (antidepressant used for sedating properties for sleep) 100 mg. each evening for insomnia, Seroquel (anti psychotic medication) 150 mg. daily for dementia with psychosis and aggression and Ativan (antianxiety medication) 0.5 mg. every 12 hours for anxiety reaction.</p> <p>R21's current care plan dated 12/9/11 for psychotropic medications potential for adverse side effects related to use of anxiety medication, anti psychotic medication. Interventions included: medicate as ordered: Seroquel, Trazodone, and lorazepam (Ativan). Evaluate effectiveness and adverse effects of medication.</p> <p>The nurse aides instructions in the electronic medical record (EMR) for monitoring was to document any physically aggressive, verbally aggressive behaviors. document interventions and outcomes. Notify nurse of any unchanged or worsening behaviors. There was not an approach to monitor R21's sleep.</p> <p>The nursing documentation on the EMR had no specific instructions on what behaviors to monitor for and sleep was not mentioned in the mood and</p>	F 329	<p>2. All residents on anti-psychotic medications have the potential for risk of not having side effects of medication documented. Residents on medications for sleep have potential risk of not having sleep patterns monitored. The RNACs will do a chart review of all orders for residents to identify those on sleep aides and anti-psychotics. Once identified, the behavior and sleep patterns will be added to the nurses to do list for documentation.</p> <p>3. All nurses will be in-serviced by the nurse educator on documenting side effects of anti-psychotic medications. All nurses will be in-serviced by the staff educators in documenting on behaviors and sleep patterns.</p> <p>4. The unit supervisors will do a random audit of up to five charts per month on residents identified as being on anti-psychotic medications. The documentation completed on side effects will be reviewed and reported on a quarterly QI for compliance by each unit supervisor.</p>	10/8/12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 32 behavior section.</p> <p>Review of the side effect monitoring for the use of psychoactive medications revealed that between 8/1 and 8/22/12 staff documented only twice that they assessed for side effects 8/4 and 8/11/12.</p> <p>An interview on 8/23/12 at approximately 3 PM with E3 (Director of Nursing) confirmed that sleep and side effect monitoring were not consistently being done.</p> <p>2. R43 had diagnoses which included depressive disorder, anxiety associated with depression, and insomnia.</p> <p>The resident had current physician's orders dated 8/14/12 that included Xanax 0.25 mg. (anti-anxiety medication) three times a day for anxiety associated with depression, first gradual dose reduction, please monitor for any changes in anxiety symptoms. R43 also had an order dated 8/10/12 for zolpidem (hypnotic) 5 mg daily for insomnia, previous order was dated 12/21/11 for each evening as needed for insomnia.</p> <p>The resident had a care plan for psychotropic medication use potential side effects from antidepressants, anti anxiety and hypnotic medications. The interventions included nurse monitoring for adverse effects and to monitor effectiveness of the medication and nurse aides to report unusual behavior.</p> <p>Review of the physician progress note dated 8/10/12 documented "long history of insomnia, reports he can not sleep without his sleeping pill, prefers to receive at 7 pm as he goes to bed by 8</p>	F 329			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 33 or 8:30".</p> <p>Review of the mood and behavior charting done by the nurses and aides lacked evidence that R43's sleep patterns were being monitored.</p> <p>Review of the EMR revealed that side effect monitoring was documented one time between 8/1 to 8/22/12.</p> <p>An interview on 8/21/12 at 12:30 PM interview with E22 (Nurse Unit Manager) revealed that the specific behaviors that needed to be monitored for R43 were not identified in the EMR therefore there was no evidence that sleep was being monitored. E22 further revealed that specific side effect monitoring could not be found for R43.</p> <p>3. R72 had a diagnosis of insomnia initiated on 12/08/11, for which, he was being given Trazodone HCl, 50 mg, at bedtime, daily.</p> <p>There were no potential side effects being monitored for this resident. The potential outcomes of this medication regime were not being monitored. R72 continued to receive Trazadone for insomnia on a daily basis.</p> <p>An interview on 8/24/12 with E11 (Registered Nurse Assessment Coordinator) confirmed that the hypnotic medication effects for insomnia were not being monitored for this resident.</p> <p>4. Review of the August 2012 physician's order sheet and MAR revealed that R95 was ordered and administered Seroquel 25 mg. at bedtime daily for dementia related psychotic disturbance with gradual dose reduction discontinued due to</p>	F 329			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	<p>Continued From page 34</p> <p>return of behaviors of striking at staff and unable to re-direct.</p> <p>R95 had a care plan titled "physical aggression as evidenced by hitting/scratching, kicking/hitting. Verbal aggression as evidenced by verbal threats, yelling/cursing at staff/others. The interventions included administer medications as ordered, assess for effectiveness and adverse effects.</p> <p>Review of the EMR revealed that side effect monitoring was documented three times between 8/1/12 to 8/23/12.</p> <p>An interview with E3 on 8/23/12 at approximately 1 PM confirmed that the facility failed to consistently monitor the potential side effects of the routine Seroquel.</p> <p>5. Review of the August 2012 physician's order sheet and MAR revealed that R114 was ordered and administered lorazepam .5 mg. daily at 9 AM and .25 mg. at 5 PM daily for anxiety.</p> <p>R114 had a care plan titled "physical aggression as evidenced by hitting/scratching, kicking/hitting. Verbal aggression as evidenced by verbal threats, yelling/cursing at staff/others. The interventions included administer medications as ordered, assess for effectiveness and adverse effects.</p> <p>Review of the EMR revealed that side effect monitoring was documented one time between 8/1/12 to 8/23/12.</p> <p>An interview with E3 on 8/23/12 at approximately</p>	F 329			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 329	<p>Continued From page 35</p> <p>1 PM confirmed that the facility failed to consistently monitor the potential side effects of the routine lorazepam.</p> <p>6. Review of the August 2012 physician's order sheet and MAR revealed that R102 was ordered and administered Clonazepam 1 mg. p.o. (by mouth) at bedtime daily for general anxiety disorder and Risperadal (anti-psychotic medication) 0.25 mg p.o. every 12 hours for behaviors-shouting constantly, unable to redirect, striking.</p> <p>R102 had a care plan for refusal of care, kicking/hitting, yelling/cursing at others and a care plan for cognitive loss which included behaviors of physically and verbally disruptive. Interventions included to administer medication as ordered assess for effectiveness and adverse effects.</p> <p>Record review lacked evidence of monitoring of side effect of the above medications.</p> <p>An interview with E10 (Nurse) on 8/22/12 at approximately 12 noon revealed that the facility monitored side effects by completing an AIMS (Abnormal Involuntary Movement Scale) assessment every six months.</p> <p>Review of the EMR revealed that side effect monitoring was documented one time between 8/1/12 to 8/23/12.</p> <p>7. Review of the August 2012 physician's order sheet and MAR revealed that R64 was ordered and administered Clonazepam 0.25 mg. p.o. every 12 hours for general anxiety disorder.</p>	F 329			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 329	Continued From page 36 R64 had a care plan 12/2/11 for combative behaviors towards staff and other residents. Interventions included to administer medication as ordered assess for effectiveness and adverse effects. Record review lacked evidence of monitoring of side effect of the above medications. Review of the EMR revealed that side effect monitoring was documented one time between 8/1/12 to 8/23/12. 8. Review of the August 2012 physician's order sheet and MAR revealed that R57 was ordered and administered Zyprexa 5 mg. p.o. twice a day for general anxiety disorder. Review of the EMR revealed that side effect monitoring was documented six times between 8/1/12 to 8/23/12. An Interview on 8/24/12 with E11 confirmed that medication side effects were not consistently monitored by the nurses.	F 329			
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically	F 334			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 334	<p>Continued From page 37</p> <p>contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p>	F 334	<ol style="list-style-type: none"> 1. R1 is currently out of the facility. The pneumococcal vaccine will be offered to him on his return. 2. All residents in our facility under the age of 65 have the potential to be at risk for not being offered a second pneumococcal vaccine per our policy in place at time of survey. The ADON completed an audit of all residents under the age of 65 to determine immunization status (Attachment 12A). Three residents were identified. RI – one for which a vaccine will be offered on return, a second that declined and a third that the physician assessed and addressed. 3. The policy and procedure and consent form has been revised based on CDC recommendations (Attachment 12B). All nursing staff will be in-serviced by staff educator on the revised policy. 4. The infection control nurse (ICN) will review all new admissions for immunizations status. ICN will maintain a tracking tool to identify those residents that need to be addressed with a pneumococcal vaccine. The ICN will report at quarterly QI the compliance status of immunizations. 	9/14/12	9/30/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 334	<p>Continued From page 38</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and review of the facility's policy and procedure, it was determined that the facility failed to offer a second pneumococcal immunization for one (R1) out of five sampled residents. Findings include:</p> <p>R1 was admitted to the facility on 1/17/12. Record review revealed that R1 was administered the pneumococcal immunization in 2003 at which time he was 49 years of age.</p> <p>Review of the facility's policy titled "Pneumococcal Immunizations-Residents" documented that each resident will be offered the immunization. Specifically:</p> <p>"I. Policy:</p> <p>C. The Physician may also, based on assessment, determine that a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or</p>	F 334			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 334	Continued From page 39 the resident or resident's legal representative refuses the second immunization." The policy included a "Pneumococcal Immunization Informed Consent Form" which documented: "Why take the Vaccination? If you received the vaccination before the age of 65 and it has been at least 5 years since you received it, a second dose is recommended."	F 334			
F 368 SS=F	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by:	F 368	1. The current meal times and bed time snack availability will be presented by the food service director at the resident council meeting. Residents will vote and would be determined by majority vote by resident population the current meal/snack schedule and agree that their needs are being met. Each unit has a kitchenette where snacks are kept per par level established by nursing and dietary to offer residents.	9/19/12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 368	<p>Continued From page 40</p> <p>Based on interview and review of facility documents it was determined that the facility failed to ensure approval from the resident group was obtained when dinner and breakfast were scheduled 14 1/2 hours apart and failed to ensure a nourishing evening snack was offered to all residents. Findings include:</p> <p>Review of the meal service times revealed that tray delivery to the units are between 4:40 PM and 5:00 PM and dinner is served in the dining room from 5:00 PM to 6:00 PM. Late trays are delivered with the evening snacks at 6:00 PM. The dining room does not open for breakfast until 7:30 AM. Evening snacks were available on each unit at the following times: Gold and Red unit- 8:00 PM, Green unit 8- 9:00 PM and Blue unit 7- 9:00 PM.</p> <p>An interview on 8/23/12 with the resident council president revealed that the evening snacks were placed in an accessible area for residents/family members. He was unaware of the council's approval for the meal span or snacks provided and could not confirm that all residents were offered snacks.</p> <p>An interview with E21 (food service director) on 8/23/12 at 10:00 AM confirmed that more than 14 hours existed between the meals but snacks (itemized list with quantities) were provided daily to each unit and sandwiches were also sent on the evening service cart for any resident to consume. E21 was unaware of whether or not the resident group had approved of meal times.</p> <p>An interview on 8/23/12 at 11:40 AM with E1 (administrator) revealed that there was no</p>	F 368	<p>2. The meal times in the facility affect all residents. The availability of snacks affects all residents.</p> <p>3. Nursing will be in-serviced by the staff educators on offering snacks during evening shifts. A button will be created in the Electronic Medical Record for staff to document if resident accepted or refused snack offering.</p> <p>4. Nursing supervisors will pull reports on snack documentation and will investigate when documentation is not in place. Rounds are done on the units by the supervisors and they will speak to residents to ensure snacks are being offered.</p>	9/30/12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 368	Continued From page 41 resident approval of the meal times or the snacks provided. After the residents council minutes were reviewed on 8/23/12 at 2:00 PM, E23 (activities director) confirmed these findings and scheduled meals times and snacks for review at the next council meeting on 8/30/12.	F 368			
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure the licensed pharmacist reviewed the drug regime for side effect monitoring for six (R21, R43, R95, R114, R64, and R57) out 37 sampled residents. Findings include: 1. Cross refer F329 example #1 R21 had current physician orders for Trazadone (antidepressant used for sedating properties for sleep) 100 mg each evening for insomnia, Seroquel (anti psychotic medication) 150 mg daily for dementia with psychosis and aggression and ativan (anxiety medication) 0.5 mg every 12	F 428	1. We cannot go back and add documentation to the resident charts. R21, R43, R95, R114, R64 and R57 all have documented monitoring of side effects of medication. (Attachments 11B-11F) 2. All residents have the potential to be at risk for not having their drug regimen reviewed by the licensed pharmacist. The facility has contracted with a new pharmacy and a new pharmacy consultant is on staff. (Attachment 13) 3. The pharmacy consultant will make weekly visits to do drug regimen reviews. All reviews will be given to DON to review with the medical team. Copies of the review will be kept in the electronic medical record and a paper copy will be kept in the DON office. The DON will monitor that all residents are being reviewed for side effects of medications. 4. The pharmacy consultant will attend quarterly QI meetings to report on all aspects of weekly visits.	9/1/12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 428	<p>Continued From page 42 hours for anxiety reaction.</p> <p>Review of the side effect monitoring for the use of psychoactive medications revealed that between 8/1 and 8/22/12 staff documented only twice that they assessed for side effects 8/4 and 8/11/12.</p> <p>The consultant pharmacist monthly review dated 8/18/12 lacked evidence that side effect monitoring was addressed.</p> <p>2. Cross refer F329 example #2</p> <p>R43 had current physician's orders dated 8/14/12 that included Xanax 0.25 mg. three times a day for anxiety associated with depression, first gradual dose reduction, please monitor for any changes in anxiety symptoms. R43 also had an order dated 8/10/12 for zolpidem (hypnotic) 5 mg. daily for insomnia, previous order was dated 12/21/11 for each evening as needed for insomnia.</p> <p>Review of the electronic medical record (EMR) revealed that side effect monitoring was documented one time between 8/1 to 8/22/12.</p> <p>The consultant pharmacist monthly review dated 8/18/12 lacked evidence that side effect monitoring was addressed.</p> <p>3. Cross refer F329, example #4.</p> <p>Review of the August 2012 physician's order sheet and MAR revealed that R95 was ordered and administered Seroquel 25 mg. at bedtime daily for dementia related psychotic disturbance</p>	F 428			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 428	<p>Continued From page 43</p> <p>with gradual dose reduction discontinued due to return of behaviors of striking at staff and unable to re-direct. Review of the EMR revealed that side effect monitoring was documented three times between 8/1/12 to 8/23/12.</p> <p>Review of the monthly Medication Regime Review (MRR) completed from June 2011 through August 2012 failed to identify the lack of monitoring of the potential side effects of the use of Seroquel.</p> <p>4. Cross refer F329, example #5.</p> <p>Review of the August 2012 physician's order sheet and MAR revealed that R114 was ordered and administered lorazepam .5 mg. daily at 9 AM and .25 mg. at 5 PM daily for anxiety.</p> <p>Review of the EMR revealed that side effect monitoring was documented one time between 8/1/12 to 8/23/12.</p> <p>Review of the monthly MRR from October 2011 through August 2012 failed to identify the lack of monitoring of the potential side effects of the use of routine lorazepam.</p> <p>5. Cross refer F329, example #7</p> <p>Review of the August 2012 physician's order sheet and MAR revealed that R64 was ordered and administered Clonazepam 0.25 mg. p.o. every 12 hours for general anxiety disorder.</p> <p>Record review lacked evidence for monitoring of the side effect of the above medications.</p>	F 428			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012	
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 428	<p>Continued From page 44</p> <p>Review of the EMR revealed that side effect monitoring was documented one time between 8/1/12 to 8/23/12.</p> <p>Review of the monthly MRR completed from February 2012 through August 2012 failed to identify the lack of monitoring of the potential side effects of the use of Clonazepam.</p> <p>6. Cross refer F329, example #8.</p> <p>Review of the August 2012 physician's order sheet and MAR revealed that R57 was ordered and administered Zyprexa (anti-psychotic medication) 5 mg. p.o. psychotic features.</p> <p>Review of the EMR revealed that side effect monitoring was documented six times between 8/1/12 to 8/23/12.</p> <p>Review of the monthly MRR completed from October 2011 through August 2012 failed to identify the lack of monitoring of the potential side effects of the use of Zyprexa.</p>			F 428			
F 431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted</p>			F 431			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 431	<p>Continued From page 45</p> <p>professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations in the medication storage areas on 8/23/12, it was determined that the facility failed to properly store and label medications. Findings include:</p> <p>Observation of the Red Unit's medication storage on 8/23/12 at 2:45 PM with E33 (Nurse) and E34 (Nurse) revealed:</p> <ul style="list-style-type: none"> - Two bottles of unopened Novolog insulin 10 ml (milliliter) with an expiration date of 7/2012. - One bottle Novolog 10 ml labeled with a open date of 6/21/12. 	F 431	<ol style="list-style-type: none"> 1. The bottles of expired insulin were discarded when found during survey. 2. There is risk that any medication in use can become expired and remain in use. The pharmacy policy and procedure on acceptable time frames of medication use will be placed in the front of all MARs as a reference (Attachments 14). 3. All nurses will be educated by the staff educator on checking expiration dates on medications. 4. The nursing supervisor on each unit will assign a staff member to check the medication carts and medication rooms once a week to ensure staff members are in compliance with expiration dates. The pharmacy consultants will make weekly visits and will randomly check medication carts for expired drugs. Any expired medications will be discarded. The pharmacy consultants will give DON a monthly report of cart/medication checks. 	8/24/12	9/30/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 431	Continued From page 46 An interview with E33 and E34 (Nurse) immediately after the above observation confirmed that insulin may only be used 28 days after opening.	F 431			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	F 441	1. We cannot go back and make any changes to what was found during survey. A reminder memo was sent out to staff about the use of Cavi Wipes to clean the glucometer in between residents use as per policy (Attachment 15A). 2. There is potential risk for all residents that get a finger stick if staff members do not follow policy to clean the glucometer. If staff members do not follow policy on proper hand washing, all residents are at potential risk for infection. All staff will be in-serviced on the policy of proper hand washing by the staff educators. All nurses will be in-serviced on the policy to properly clean the glucometer after each use. 3. A reminder for cleaning the glucometer with Cavi Wipes created and attached to med carts (Attachment 15B). Unit supervisors will make random rounds to ensure staff members are cleaning glucometers correctly. 4. Hand washing and glucometer cleaning has been added to the nurses' medication audit that is given to all nurses on a rotating cycle date by the building supervisors. Results of the audits will be summarized and reported at quarterly QI by the building supervision (Attachment 15C).	9/30/12 9/30/12 9/14/12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 47</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility policy and procedures it was determined that the facility failed to ensure proper infection control techniques during hand washing and glucometer usage. Findings include: Review of the facility's policy titled "ACCU-CHEK System" indicated: C. Care of, cleaning, and disinfecting the meter: 1. Cleaning and disinfecting of the meter will be done between each resident test. 1b. Wipe the outside of the meter with an EPA provide germicidal disinfectant labeled effective against TB (Tuberculosis) or HBV (Hepatitis Virus)."</p> <p>1a. During medication administration observation on 8/16/12 at approximately 4:13 PM, E5 (Nurse) used the glucometer to obtain blood from R25 . After using the glucometer, E5 placed the glucometer back in the medication cart drawer without cleaning the device. An interview immediately after the above observation with E5 revealed that cleaning of the device was completed daily by the 11 PM-7 AM staff, thus, no cleaning of the glucometer was needed during her shift including in between resident use.</p> <p>1b. During medication administration observation on 8/16/12 at approximately 4:37 PM, E6 (Nurse) used the glucometer to obtain blood from R51.</p>	F 441			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	Continued From page 48 After using the glucometer, E6 used alcohol pad to clean the glucometer. An interview immediately after the above observation with E6 revealed that she utilized the Cavi Wipe (an approved EPA disinfectant) at the beginning of her shift, however, in between resident use, she incorrectly utilized the alcohol pad to clean the device. An interviews with E7 (Nurse) and E8 (Nurse) at approximately 4:50 PM and 4:55 PM respectively on 8/16/12 revealed that they used alcohol pad to clean the glucometer in between resident use. An interview with the E4 (Assistant Director of Nursing) on 8/16/12 at 5:10 PM confirmed that alcohol pad was not an EPA approve disinfectant to clean the glucometer in between resident use and that the expectation was that an approved EPA disinfectant be utilized to clean the glucometer in between resident use.	F 441			
F 469 SS=F	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents.	F469	1. The insect control fan at the front entrance was lowered to help with full air flow to cover entire door opening. Gaskets have been added to the front entrance door to close any gaps where insects may enter. The staff exit traffic pattern was redirected; employees use the exit by the loading dock to leave the building instead of the exit by the dining hall, as the door is primarily used by residents and has an extended time release to close. The pest control company has initiated additional new fly bait to the outside of perimeters of the building. The maintenance staff continues weekly power washes of the kitchen dock area to minimize any food or grease deposit buildup. This occurs during high peak season: April 1 st to November 1 st . A bug zapper was installed at the kitchen loading dock. Blue lights in the main resident dining room are left on daily; light bulbs are changed monthly during peak season.	9/12/12 9/13/12 8/23/12 9/7/12 8/10/12 7/26/12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 469	Continued From page 49 This REQUIREMENT is not met as evidenced by: Based on observations throughout the facility during the survey, it was determined that the facility failed to keep the facility free of flies. Findings include: Flies were observed in all areas of the building throughout the duration of the survey (8/16/12 to 8/24/12) and included the following observations: 1. On 08/16/12 at 7:57AM, a tray was left for R8 at the red unit nurse's station. Two (2) flies were observed to landing on and crawling over the tray for several minutes. 2. On 08/16/12 at 11:35AM, R72 was lying in bed watching television. A fly was observed crawling on his arm. 3. On 08/17/12 at 9:00AM, one fly was observed to be flying around the gold unit nurse's station. 4. On 08/20/12 at 12:06PM, one fly was observed at the gold unit nurse's station. The pest control vendor includes fly abatement in the contract with the facility. Fly control products were applied and inspections throughout the building by the vendor revealed no pest activity on the following dates: 05/04/12, 05/07/12, 05/14/12, 05/21/12, 06/01/12, 06/08/12, 06/15/12, 06/22/12, 06/29/12, 07/03/12, 07/20/12, 07/27/12, 08/10/12, and 08/17/12.	F 469	2. All residents are at risk of being affected by flies, if an effective pest control program has not been maintained. 3. The maintenance department will complete daily rounds to check for insects. This information will be put in the pest control log (16A & 16B). Maintenance will conduct monthly audits to monitor effectiveness of interventions. 4. Audits will be completed by the maintenance department on a monthly basis to monitor the effectiveness of the interventions which includes: items listed on #1. The Maintenance Superintendent will report his findings at quarterly QI meetings.		
F 502 SS=E	483.75(j)(1) ADMINISTRATION	F 502			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 502	Continued From page 50 The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R114) out of 37 sampled residents the facility failed to obtain laboratory services to meet the needs of the resident. Findings include: R114 had a physician order dated 11/1/11 for Depakote (used to treat a abnormal moods) level (laboratory test to determine level of Depakote in the blood) to be completed every month. Record review revealed Depakote levels were completed on 11/1/11, 4/17/12, 5/15/12, 6/13/12, and 7/17/12. Record review lacked evidence of the test for 12/11, 1/12, 2/12, and 3/12. Interview with E4 (Assistant Director of Nursing) on 8/22/12 at approximately 3 PM confirmed the findings.	F 502	1. R114 currently has new orders for every three months to begin in October (Attachment 17A) for lab draws. R114 did have a valporic acid drawn on 8/21/12 (Attachment 17B). 2. All residents with routine recurring lab orders have the potential to be at risk for lab work not being completed. An audit will be completed by ADON to ensure all recurring lab orders for September have been completed and results are on file. 3. A new lab process will be initiated and in-serviced to the nursing staff by staff educators (Attachment 17C). 4. The Office Support Specialist (OSS) on each unit will audit lab requests, lab draws and lab results and report findings at quarterly QI meetings.	10/1/12	10/1/12
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the	F 514			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER DELAWARE VETERANS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 100 DELAWARE VETERAN'S DRIVE MILFORD, DE 19963		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	<p>Continued From page 51</p> <p>resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that for one out of 37 sampled residents the facility failed to ensure the current physician's order was accurately transcribed to the CNA assignment sheet and care plan. Findings include:</p> <p>R38 was admitted to the facility with diagnoses including PEG tube, malabsorption, atrial fibrillation, prostate cancer and diarrhea.</p> <p>Review of R38's records revealed a physician's order dated 8/13/12 that stated "patient is to remain on bedrest until further notice due to wound and skin issues".</p> <p>Interview with E29 (CNA) on 8/21/12 revealed the instruction to get R38 out of bed was noted in the ECC/electronic system CNA assignment. Review of R38's printed CNA care assignment observed on 8/21/12 documented "AM walk in room and AM walk in hall."</p> <p>An interview on 8/22/12 at 11:05 AM with E11 revealed the discrepancies between the physician's order and the CNA worksheet were not picked up by the nurses who reviewed the order. Review of R38's care plan in ECC also noted "out of bed to chair" under the approach section for the nurse aide. E11 immediately</p>	F 514	<ol style="list-style-type: none"> 1. Current physician's orders are accurately transcribed to the CNA assignment sheet and care plan (Attachment 18 A-C). 2. All residents have a potential risk for not having nursing assistant assignment sheets and care plans reflect current physician orders. Nursing leadership will review orders and assignment sheets and care plans to ensure all are accurate. Nurses will be in-serviced by the staff educators on viewing new orders and adding applicable ones to the CNA assignment sheets. 	10/1/12 9/30/12	

PRINTED: 09/07/2012
FORM APPROVED
OMB NO. 0938-0391

FORM CMS-2567(02-99) Previous Versions Obsolete



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

Page 1 of 2

NAME OF FACILITY: Delaware Veterans Home

DATE SURVEY COMPLETED: August 24, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced annual survey and complaint visit was conducted at this facility from August 16, 2012 through August 24, 2012. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 115. The stage two survey sample was thirty-five (35).</p>	<p>Cross reference the CMS 2567-L survey report date completed 8/24/12, F156, F226, F241, F248, F272, F279, F280, F309, F314, F315, F323, F329, F334, F368, F428, F431, F441, F469, F502, F514.</p>
3201	Skilled and Intermediate Care Nursing Facilities	
3201.1.0	Scope	
3201.1.2	Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.	
	This requirement is not met as	

Provider's Signature

William Petersen

Title

Administrator

Date

9/17/12



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

Page 2 of 2

NAME OF FACILITY: Delaware Veterans Home

DATE SURVEY COMPLETED: August 24, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
---------	--	--

evidenced by:

Cross refer to the CMS 2567-L survey
report date completed 8/24/12, F156, F226,
F241, F248, F272, F279, F280, F309,
F314, F315, F323, F329, F334, F368,
F428, F431, F441, F469, F502, F514.